



Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEDI-LAB CORPORATION
SUITE 200
412 W. BROADWAY
GLENDALE CA 91204

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-13-2847-01

MFDR Date Received

June 26, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have exhausted all resources with Texas Mutual and have decided to move forward with filing this claim as a medical dispute with Texas Department of Insurance for resolution."

Amount in Dispute: \$1,250.09

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual reviewed its claim files and found (B) (i-iii) does not apply...The DWC MDR date stamp listed on all the DWC-60s is 6/26/13. Of the 127 disputes, 121 have dates of service beyond the one year timeline of Rule 133.307...The requestor has waived its right to DWC MDR in these 121. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

| Service Date(s) | Disputed Services | Amount In Dispute | Untimely to MFDR |
|---|---------------------|-------------------|------------------|
| November 4, 2011 through November 4, 2011 | Urinary Drug Screen | \$1,250.09 | \$0.00 |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, 37 Texas Register 3833, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for clinical laboratory services
3. The services in dispute were reduced/denied, in part, by the respondent with the following reason codes:
 - Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason.)
 - The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
 - ODG documentation requirements for urine drug testing have not been met.

Issues

Was the requestor required to file for dispute not later than one year after the service?

Did the requestor waive the right to medical fee dispute resolution?

Findings

The respondent in its position states "Texas Mutual reviewed its claim files and found (B) (i-iii) does not apply...The requestor has waived its right to DWC MDR." 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service (DOS) in dispute." The division concurs with the respondent in that the request for medical fee dispute does not involve issues identified in 28 Texas Administrative Code §133.307 (B) (i-iii). For that reason, the division concludes that the requestor was required to file for medical fee dispute resolution not later than one year after the dates of service in dispute.

The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on June 26, 2013. The services in dispute were untimely based upon the medical fee dispute resolution received date of June 26, 2013. The division concludes that the provider has waived its right to medical fee dispute resolution for the disputed services.

Conclusion

For the reasons stated above, the Division finds that the requestor has waived its right to medical fee dispute resolution. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

August 7, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

